

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: March 12, 13, 14, 15, 16, 22, 23, and 26, 2012</p> <p>Facility number: 000314 Provider number: 155478 AIM number: 100274210</p> <p>Survey team: Terri Walters RN TC Carole McDaniel RN Martha Saull RN Dorothy Watts RN</p> <p>Census bed type: SNF/NF: 69 Total: 69</p> <p>Census Payor type: Medicare: 9 Medicaid: 47 Other: 13 Total: 69</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 3/29/12 Cathy Emswiller RN</p>			F0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review on or after</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2012

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observation, record review and interview the facility failed to ensure residents were safe to self administer medications for 1 of 16 residents who were observed receiving medication. Resident # 2</p> <p>Findings include:</p> <p>On 3/13/12 at 4:30 P.M., RN #3 was observed administering routine medication to Resident #2. She prepared medications including Tylenol, Carvediol (for High blood pressure control), Glipizide (for Diabetic blood sugar control), Colace (stool softener) and Fish oil capsules. She left the medication with the resident at the resident's bedside without ensuring medications were taken.</p> <p>On 3/14/12 at 10:30 A.M. the resident record was reviewed. Documentation was lacking to indicate the resident met appropriate criteria for self medication administration. There was no physician order for self administration.</p>		F0176	<p>It is the facility's intent to ensure residents are safe to self administer medication.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>1. Resident # 2 was assessed which determined to have the ability to self administer medication. 2.R.N. # 2 was counseled. 3.R.N. # 2 was placed into orientation for re-training and completion of validation skills check off list completed.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>1. No other residents self administer medication. 2. License Nurses were in-serviced by DNS on 4/5/12 regarding med pass</p>		04/10/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>During interview with the Director of Nursing on 3/16/12 at 12:20 PM, she indicated residents were to be screened for appropriateness to self administer medications and also have a physician order for it.</p> <p>3.1-11(a)</p>			<p>administration medication policy.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>1. License Nurses were in-serviced by DNS on 4/5/12 regarding med pass administration which included self administered medication policy.</p> <p>2. Validation skill check offs for med pass will be completed on each licensed nurse on all three shifts completed by DNS and/or designee.</p> <p>3. RN # 3 was placed in orientation for re-training and validation skill check off completed for med pass.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>1. To ensure compliance, the DNS/Designee is responsible for the completion of the Med Pass Procedure check off list CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
				consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0253 SS=D	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interview, the facility failed to ensure the environment was free of objectionable odors for the first 2 survey days of 7 survey days. 3/12/12 and 3/13/12</p> <p>Findings include:</p> <p>On 3/12/12 at 9:40 A.M., the building was entered for initial tour. Upon entering the building from the main entrance door, the following floor plan was observed: the nursing station for the 300 and 400 halls was to the left of the entry intersection. The 300 nursing unit hall was located vertical to the entry door. The 400 nursing unit hall was located to the right of the entry doorway. Directly to the right of the main door was a resident TV room with the doorway to the room facing the 400 unit hall. Directly across the hall from the TV room, was a men's shower room and a women's shower room, again with the doors opening into the 400 unit hall. At this time, 4 residents were observed sitting in their wheelchairs in the TV room. Also at this time, 2 residents</p>		F0253	<p>The facility's intent is to ensure the environment is free from objectionable odors.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>1. No residents were affected. 2.Exhaust fan repaired 3/22/12.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <p>1. No residents were affected. 2.Laundry barrels will be disinfected once a week. 3.Soiled briefs barrel will be emptied once per shift and more often as needed. 4.Laundry barrels will be emptied at least 2 times per laundry and more often as needed. 5.Exhaust fan repaired.</p>		04/10/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>were observed sitting in their wheelchairs at the entry intersection.</p> <p>On 3/12/12 at 10:05 A.M., during initial tour of the 300 hall, a pervasive foul odor of human excrement and urine was noted radiating from the men's shower room. At this time, observed in the men's shower room were 4 barrel type trash receptacles filled with soiled depends and other refuse. Two of the barrels were full to the point of the lids being unable to be securely closed. This pervasive foul odor remained to be detected at 11 A.M., 12 P.M., 1 P.M. and 2 P.M.</p> <p>On 3/12/12 at 12:08 P.M., a confidential family member was interviewed. This confidential family member indicated they detected "a strong BM odor in the 300 and 400 halls frequently." They also indicated they "wondered why the workers at the facility don't notice the odor."</p> <p>On 3/13/12 at 10 A.M., there again was a pervasive stale urine odor noted in the 300 and 400 halls at the intersection of the nurses station and shower rooms. This pervasive foul odor remained to be detected at 11 A.M., 12 P.M., 1 P.M. and 2 P.M. At this time, 3 residents were observed in the TV room in their wheelchairs.</p>			<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ol style="list-style-type: none"> 1. Laundry barrels will be disinfected once a week. 2. Soiled briefs barrel will be emptied once per shift and more often as needed. 3. Laundry barrels will be emptied at least 2 times per laundry and more often as needed. 4. Exhaust fan will be placed on the preventative schedule to be checked monthly. 5. The License Nurse will monitor shower rooms for cleanliness/odor each shift 7 days a week. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ol style="list-style-type: none"> 1. The Maintenance Director will check operation of exhaust fan monthly during preventative maintenance check and documented on preventative sheet. 2. To ensure compliance, the DNS/Designee is responsible for the completion of the Nurse 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Also at this time, 1 resident was observed sitting at the nursing station intersection awaiting a ride for an appointment. At 11:30 A.M., residents were observed sitting at this intersection awaiting staff to push them in their wheelchairs to the dining room.</p> <p>On 3/22/12 at 11:30 A.M. CNA (Certified Nursing Assistant) #10 was interviewed. CNA #10 indicated she was working on the 300 and 400 nursing units today. She indicated resident showers are given in both the units men's and women's shower rooms. CNA #10 indicated usually the women's shower room is used as the heater and ventilation doesn't work in the men's shower room. CNA #10 indicated soiled resident clothing, towels and sheets were stored in the barrels housed in one of the two shower stalls in the men's shower room.</p> <p>On 3/22/12 at 3:05 P.M., the Mens shower room on the 300/400 unit was toured with the Maintenance staff. Just inside the door, were two switches located on the wall to the left. One of the switches operated the lights in the room when activated. The other switch,</p>				<p>Rounds CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2012

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>when activated, did nothing. At this time, the Maintenance staff removed a dust coated grate from the ceiling over the shower stall. He indicated this was the exhaust fan and that is currently wasn't working. He indicated he was unsure as to how long the fan wasn't working as he wasn't aware the fan wasn't working. At this time, 4 covered barrels were observed in one of the two shower stall areas.</p> <p>On 3/23/12 at 3:20 P.M., the ADON (Assistant Director of Nursing) was interviewed. She indicated there were 44 residents on the 300 and 400 unit halls that would use the men's and women's shower rooms.</p> <p>3.1-19(f)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interview, and record review, the facility failed to ensure adequate supervision to prevent a resident from leaving the facility unattended for 1 of 1 facility reported incidents to the state agency.</p> <p>Resident #56</p> <p>Findings include:</p> <p>On 3/15/12 at 11:00 A.M., Resident #56's clinical record was reviewed. A nursing note dated 1/8/12 at 2:50 P.M., indicated, "Pt (patient) had just been toileted x 2 per staff. He had been looking for a door to go home. He propelled himself down toward wife's room et turned left to enter 'Breezeway' he has been in this area several times has even knocked on Cottage (name of secured unit) doors. Pt found unlocked door to left et went outside to courtyard. Another res(resident) saw him et alerted staff. He was outside no more than 5 -8 min (minutes). He told staff he was checking out the engine to start but it was too cold to start. No injuries</p>			F0323	<p>The facility's intent is to ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>1. Resident #56 was started on 15 minute checks immediately and continues to wear wander guard.</p> <p>2. Motion sensor alarm placed on court yard door.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <p>1. A complete review of residents was completed and no other residents were identified.</p>		04/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>noted pt laughing about it. Sisters visiting et updated, Dr (physician's name) updated, DON (Director of Nursing) updated."</p> <p>A nursing note dated 1/8/12 at 5:00 P.M., indicated, "Pt has been on 15 min(minute) watch since above happened. No problems."</p> <p>On 3/16/12 at 11:15 A.M., a facility incident reporting form was reviewed. This report indicated Resident #56 had diagnoses which included but were not limited to: dementia with behaviors, anxiety, and psychosis. A description of the incident indicated, "Only outside 5-8 minutes T (temperature) 58 degrees (Fahrenheit). Resident opened courtyard door and got out into locked courtyard-Had been c (with) nurses before going outside." Immediate action taken: "Family and MD notified. Resident brought back into building-full body assessment done." Preventive measures taken: "Key pad to door set to be locked at all times & 15 min (minute) checks started."</p> <p>On 3/16/12 at 10:14 A.M., during interview the Director of Nursing (DON) indicated which door Resident #56 had opened and had exited the facility on 1/8/12 unsupervised. This</p>		<p>2.Elopement books which include pictures of residents and description will be reviewed and updated to reflect any necessary changes.</p> <p>3.Plan of care and C.N.A. assignment sheets have been updated to reflect changes as appropriate.</p> <p>4.Placement and function of wander guard is checked each shift by License Nurse.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>1. Plan of care and C.N.A. assignment sheets have been updated to reflect changes as appropriate.</p> <p>2.In-service for all staff by DNS/Social Service on April 10 on elopement policy and procedures.</p> <p>3.Motion sensor alarm placed on court yard door.</p> <p>4.Alarm pad is utilized to enter court yard from facility.</p> <p>5.Device received to check motion detector bracelets for functioning.</p> <p>6.Placement and function of wander guard is checked each shift by License Nurse.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>exit door was to the left of the door to the secured unit (cottage) when coming from the 300 hall (where Resident #56 resided). A key pad alarm was observed beside this door. The DON indicated at this time Resident #56 would have been in a wheelchair when he had exited the facility. The DON activated the keypad by the door and exited to the secured courtyard area. A large red button (above wheelchair level) was pressed on the outside of this door (in the court yard) by the DON. The DON was unable to re-enter the building by pressing the red button and turning the door knob of this exit door. On 3/16/12 at 10:25 A.M., the Administrator demonstrated the door knob had to be turned completely not just half way or the outside door would not open to enter the building.</p> <p>On 3/16/12 at 10:5., the Administrator was interviewed regarding Resident #56 exiting the facility unattended on 1/8/12. The Administrator indicated when the resident exited the facility on 1/8/12 at 2:50 P.M., the door the resident used to exit would have been unlocked in day light hours when he had exited. She indicated after this incident the facility had chosen to lock that door during day light hours also.</p>				<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>1. To ensure compliance, the DNS/Designee is responsible for the completion of the Missing Resident/Elopement QI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>She indicated at the time of the incident the resident had been in a wheelchair and the temperature had been 58 degrees. The Administrator indicated a resident who had resided in a resident room by this exit door had alerted staff to the resident being outside. She indicated at this time that other residents and families using this exit door to the courtyard area had not complained of any difficulty getting back inside the facility. During interview at this time the Administrator indicated Resident #56 had not left the facility unattended before or after the 1/8/12 incident. The Administrator also indicated that Resident #56's wander guard bracelet would not have worked on the door the resident had exited from on 1/8/12 because the courtyard area was enclosed.</p> <p>On 3/16/12 at 11:15 A.M., Resident # 56's care plan was reviewed. His care plan had been initiated on 11/19/11 and addressed the problem of " Resident is an elopement risk." The goal target date had been updated to 5/19/12. The long term goal indicated, " Resident will not leave facility unattended; resident safety will be maintained." Interventions of the care plan (initiated 11/19/11) included: to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>identify the pattern of the resident's wandering, elopement risk book at the main office and at each nurse's station, and the resident to wear a wander guard bracelet. The resident's care plan did not address the checking of the wander guard bracelet in regard to how often it would be checked or what staff was responsible for the monitoring of compliance.</p> <p>On 3/22/12 at 10:45 A.M., LPN #1 (Resident #56's nurse) was interviewed regarding checking of Resident #56's wander guard bracelet. Resident #56's March 2012 Medication Administration Record (MAR) was reviewed at this time. This record had not included documentation of the checking of the wander guard bracelet placement and function. LPN #1 indicated documentation was lacking of the checking of Resident #56's wander guard bracelet.</p> <p>On 3/22/12 at 9:20 A.M. a facility policy entitled "Missing Resident/Resident Elopement" revised on 3/10 was reviewed. This policy included but was not limited to: "...Security bracelet and alarm system will be checked on a routine basis to ensure they are functioning..." This</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>policy also indicated, "Elopement risk residents will have a security bracelet on (if the facility utilizes an electronic monitoring system) per physician's order that will be checked no less often than daily..."</p> <p>During interview on 3/23/12 at 9:20 A.M., the DON indicated the facility did not have a way to check resident wander guard bracelets except to take residents to an alarmed door to see if the alarm sounds. She indicated the facility has ordered a device (universal door/trigger tester) to check resident wander guard bracelets. She indicated the tester ordered would be at the facility tomorrow. She indicated she had written physician orders to check wander guard bracelets every shift and to document the checking on resident treatment sheets. She indicated one resident on the 500 unit already had a physician's order to check her wander guard. She indicated the checking of her wander guard had been documented on the resident's medication administration record (MAR).</p> <p>On 3/23/12 at 9:20 A.M., the Assistant Director of Nursing (ADON), indicated the facility had also ordered a motion sensor device to be</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2012

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	installed on 4/4/12, on the outside of the court yard door. 3.1-45(a)(2)						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to</p>			F0441	The facility's intent is to establish and maintain an Infection Control		04/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>ensure infection control practices were observed during medication administration by 1 of 5 nurses observed passing medications to 6 of 16 residents. Resident #79 Resident #37 Resident #56 Resident #39 Resident #32 Resident #2</p> <p>Findings include:</p> <p>On 3/13/12 from 4:00 P.M. to 4:40 P.M., RN #3 was observed passing medication.</p> <p>She was observed to prepare medication for administration to Resident #79. She administered the medication, touching the resident's hands and shoulder and articles in the room. Without hand sanitizing she to prepared medication for Resident #2. In the process a pill dropped on the floor. She picked the pill up of the floor, discarded it and continued with the preparation without hand washing and administered it. With contaminated hands, she prepared medication for Resident #32. She poured water from a pitcher on the cart into a plastic cup for the resident to drink from along with the medications in the cup. Upon completing the administration, she contacted the full rim of the contaminated glass as she placed her</p>				<p>Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>1. A review of the medical records of residents #79, #37, #56, #39, #32, #2 was completed.</p> <p>2.R.N. # 3 was counseled.</p> <p>3.R.N.#3 was placed into orientation for re-training and completion of validation skills check off list completed which included hand washing.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <p>1. No other residents were identified.</p> <p>2.License Nurses were in-serviced by DNS on 4/5/12 regarding med pass administration which included hand washing.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>1. R.N. # 3 was placed in orientation for re-training and validation skill check off completed for med pass which included infection control procedures.</p> <p>2.Validation skill check offs for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>palm down over the glass while taking it back to the medication cart for disposal. Without hand washing, she prepared the medication for Resident #56. She took water along, administered the medication and picked up the soiled water glass, in the same manner recontaminating her hands. Without hand washing she completed the series by preparing and administering medications to Resident #39 and then Resident # 37, without any hand washing throughout the entire observation.</p> <p>On 3/22/12 at 4:00 P.M. the Director of Nursing provided facility policies and procedures related to infection control. During interview at that time she indicated hand washing between care of residents was a requirement of staff. The undated Standard Precaution guideline directed hand washing between resident care or handling items which had been contaminated.</p> <p>3.1-18(b)(1) 3.1-18(l)</p>				<p>med pass which includes hand washing will be completed on each licensed nurse on all three shifts completed by DNS and/or designee.</p> <p>3. License Nurses were in-serviced by DNS on 4/5/12 regarding med pass administration which included hand washing.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>1. To ensure compliance, the DNS/Designee is responsible for the completion of the Medication Pass Procedure CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2012

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0467 SS=E	<p>483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two.</p> <p>Based on observation and interview the facility failed to ensure the male shower room provided ventilation to assist in reducing objectionable odors for 1 of 1 male shower rooms on the 300 and 400 units.</p> <p>Findings include:</p> <p>On 3/12/12 at 9:40 A.M., the building was entered for initial tour. Upon entering the building from the main entrance door, the following floor plan was observed: the nursing station for the 300 and 400 halls was to the left of the entry intersection. The 300 nursing unit hall was located vertical to the entry door. The 400 nursing unit hall was located to the right of the entry doorway. Directly to the right of the main door was a resident TV room with the doorway to the room facing the 400 unit hall. Directly across the hall from the TV room, was a men's shower room and a women's shower room, again with the doors opening into the 400 unit hall. At this time, 4 residents were observed sitting in their wheelchairs in the TV</p>			F0467	<p>The facility's intent is to have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ol style="list-style-type: none"> 1. No residents were affected. 2. Exhaust fan repaired 03/22/12. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ol style="list-style-type: none"> 1. No residents were affected. 2. Laundry barrels will be disinfected once a week. 3. Soiled briefs barrel will be emptied once per shift and more often as needed. 4. Laundry barrels will be emptied at least 2 times per laundry and more often as needed. 5. Exhaust fan repaired 03/22/12. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ol style="list-style-type: none"> 1. Laundry barrels will be disinfected once a week. 		04/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>room. Also at this time, 2 residents were observed sitting in their wheelchairs at the entry intersection.</p> <p>On 3/12/12 at 10:05 A.M., during initial tour of the 300 hall, a pervasive foul odor of human excrement and urine was noted radiating from the men's shower room. At this time, observed in the men's shower room were 4 barrel type trash receptacles filled with soiled depends and other refuse. 2 of the barrels were full to the point of the lids being unable to be securely closed. This pervasive foul odor remained to be detected at 11 A.M., 12 P.M., 1 P.M. and 2 P.M.</p> <p>On 3/12/12 at 12:08 P.M., a confidential family member was interviewed. This confidential family member indicated they detected "a strong BM odor in the 300 and 400 halls frequently." They also indicated they "wondered why the workers at don't notice the odor."</p> <p>On 3/13/12 at 10 A.M., there again was a pervasive stale urine odor noted in the 300 and 400 halls at the intersection of the nurses station and shower rooms. This pervasive foul odor remained to be detected at 11 A.M., 12 P.M., 1 P.M. and 2 P.M. At this time, 3 residents were observed</p>				<p>2. Soiled briefs barrel will be emptied once per shift and more often as needed.</p> <p>3. Laundry barrels will be emptied at least 2 times per laundry and more often as needed.</p> <p>4. Exhaust fan will be placed on the preventative schedule to be checked monthly.</p> <p>5. The License Charge Nurse will monitor shower rooms for cleanliness/odor each shift 7 days a week.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>1. The Maintenance Director will check operation of exhaust fan monthly during preventative maintenance check and documented on preventative sheets.</p> <p>2. To ensure compliance, the DNS/Designee is responsible for the completion of the Nurse Rounds CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>in the TV room in their wheelchairs. Also at this time, 1 resident was observed sitting at the nursing station intersection awaiting a ride for an appointment. At 11:30 A.M., residents were observed sitting at this intersection awaiting staff to push them in their wheelchairs to the dining room.</p> <p>On 3/22/12 at 11:30 A.M. CNA (certified nursing assistant) #10 was interviewed. CNA #10 indicated she was working on the 300 and 400 nursing units today. She indicated resident showers are given in both the units men's and women's shower rooms. CNA #10 indicated usually the women's shower room is used as the heater and ventilation doesn't work in the men's shower room. CNA #10 indicated that soiled resident clothing, towels and sheets were stored in the barrels housed in one of the two shower stalls in the men's shower room.</p> <p>On 3/22/12 at 3:05 P.M., the Mens shower room on the 300/400 unit was toured with the Maintenance Man. Just inside the door, were two switches located on the wall to the left. One of the switches operated the lights in the room</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2012	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>when activated. The other switch, when activated, did nothing. At this time, the Maintenance Man removed a dust coated grate from the ceiling over the shower stall. He indicated this was the exhaust fan and that is currently wasn't working. He indicated he was unsure as to how long the fan wasn't working as he wasn't aware the fan wasn't working. At this time, 4 covered barrels were observed in one of the two shower stall areas.</p> <p>On 3/23/12 at 3:20 P.M., the ADON (Assistant Director of Nursing) was interviewed. She indicated there were 44 residents on the 300 and 400 unit halls that would use the men's and women's shower rooms.</p> <p>3.1-19(f)(2)</p>						